Montgomery vs. Cuomo

Exhibit Group C

Exhibit #4 – NYS Senate Hearing Transcript (May 31, 2013)

BEFORE THE NEW YORK STATE SENATE
STANDING COMMITTEE ON MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

PUBLIC HEARING:

TO LOOK AT THE IMPLEMENTATION AND IMPACT OF THE MENTAL HEALTH REQUIREMENTS IN THE NEW YORK SAFE ACT

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250 Broadway, 19th Floor
Senate Hearing Room
New York, New York 10007

May 31, 2013
2:00 p.m. to 5:00 p.m.

PRESIDING:

Senator David Carlucci
Chair

SENATE MEMBERS PRESENT:

Senator David J. Valesky

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SENATOR CARLUCCI: Good afternoon.

I want to thank everyone for coming today.

I'm Senator David Carlucci, the Chairman of the Mental Health and Developmental Disabilities Committee.

I want to thank you for attending this important hearing to address the mental-health components of the SAFE Act.

The goal here today is to hear from all of you, as respected members of your field serving people with mental-health issues, to make sure that the purpose of this law, the SAFE Act, to save lives, to protect people, to make sure that there isn't an undue burden, in terms of servicing people that need treatment for health with their issues, make sure that there is not a stigma attached.

And just, again, I want to thank you.

I know your time is valuable, so we'll move through this hearing quickly.

Today I'm joined by Senator Valesky, and I'll let Senator Valesky say a few words.

SENATOR VALESKY: Thank you very much, Mr. Chairman. I appreciate the opportunity join you here today.

I represent the Syracuse area in the

State Senate, and these issues and the implementation of the SAFE Act, and its impact on the mental-health community, is certainly a statewide issue.

So I appreciate Chairman Carlucci's leadership on this issue, and in conducting this hearing, and in taking a leadership role as a new Chair of this Committee, and he's been very active.

And I appreciate his advocacy on behalf of the entire mental-health community.

And I'm looking forward to hearing your testimony.

Thank you.

SENATOR CARLUCCI: Thank you, Senator Valesky.

We're going to start with our first speaker, who's from the Conference of Local Mental Health [sic] Hygiene Directors, Jed Wolkenbreit, who is the counsel.

Jed.

JED WOLKENBREIT: Thank you, Senator.

First of all, thank you for the opportunity to address you this afternoon.

My name is Jed Wolkenbreit. I am the counsel to the New York State Conference of Local Mental

Hygiene Directors, commonly known as "The Conference."

The Conference is a statutory organization established pursuant to Section 4110 of the Mental Hygiene Law, whose only members are the directors of community services for the city of New York and the 57 other counties in the state.

As you know, Article 41 of the Mental Hygiene Law requires that each local government establish a subdivision known as "a local governmental unit," or, an "LGU," to act as the policymaking arm of local government in the areas of mental health, developmental disabilities, and chemical abuse.

It is The Conference's role to act as the statewide spokesperson for these local governmental units.

And on a personal note, I would like to extend our best wishes from our chair, who's the Commissioner of Onondaga County, Bob Long, Senator.

On January 15th, as you know, Governor Cuomo signed the New York Secure Ammunition and Firearms Enforcement Act, commonly known as the "New York SAFE Act," into law.

Section 20 of the law adds a new section, 946, to the Mental Hygiene Law, which requires that

when a mental-health professional -- defined in the law as a physician, a psychologist, a licensed clinical social worker, or a registered nurse -- who is currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that the person is likely to engage in conduct which would cause or result in serious harm to self or others, that professional shall report the name of that person to the director of community services.

The director must then agree or disagree with the report.

And if he or she say agrees, then they report that on to the Division of Criminal Justice Services to be entered into a database, for purposes of either suspending or revoking that person's gun permit, or, ultimately, preventing that person from receiving a new permit.

As you know, there is no specificity in the statute as to how the procedure was intended to be implemented, nor, in fact, was any money appropriated to implement it.

So on January 15th, our local governments were told that we had 60 days to implement this system, and we would be given no extra resources to

do so.

Initially, it was assumed that there would be 58 different systems of reporting throughout the state.

Fortunately, the State Office of Mental Health worked with The Conference to develop what has become known as the "Integrated SAFE Act Reporting System," or, "ISARS," which is a portal which creates a single system for all mental-health professionals to file their 946 reports.

ISARS went live in an abbreviated form on March 16th, and continues to be in the state of development.

The ISARS system requires the reporter to give enough personal information so that a determination can be made that the person who is reporting is, in fact, an authorized reporter, one of the four professions authorized under the statute, and it allows the reporter to give enough clinical information so the DCS can either agree or disagree that the person being reported meets the criteria of the statute.

Indeed, much credit is due to the IT team at State Office of Mental Health, for really accomplishing this portal in a relatively short

period of time.

A two-month period to develop a whole new system like this is -- especially in state government, with all due respect, is almost unheard of.

As we read the statute, DCS needs to be assured of four things:

First, that the report made by the person defined as the mental -- is made by a person defined under the statute as a "mental-health professional";

Secondly, that the DCS is satisfied that the mental-health professional has independently exercised reasonable professional judgment;

And, third, has determined that the patient is likely to engage in the dangerous conduct set forth in the statute;

And, finally, the report must indicate that the mental-health professional is currently providing treatment services at the time that the determination is made.

We believe that if one of those criteria is not present, then the DCS should disagree with the report and not report it on to DCJS.

From the outset, most DCSs (directors of community service) throughout the state, have

believed, and we still believe as The Conference, and The Conference has advocated, that it was a mistake to include the DCS to be responsible for this type of screening.

We have taken the position from the start, that local mental-health offices are not set up or funded to carry out what is essentially a criminal-justice responsibility, and we agree with what has been said by many mental-health professionals; namely, that this reporting requirement interferes with the therapist's relationship.

And, quite frankly, local governments do not have the resources to carry out this unfunded mandate in a responsible manner.

However, while The Conference still believes that the DCS should not be involved in this procedure, our members have tried to do their best in carrying out their new obligations, under the law.

As counsel to The Conference, much of my time for -- frankly, for the last two and a half months, has been spent dealing with questions and concerns regarding the SAFE Act.

Since March 16th, there have been over

6,000 reports made through the ISARS system, with about two-thirds of those coming from here in New York City.

The vast majority, over 92 percent, come from hospitals, primarily Article 28 hospital emergency departments and psychiatric units.

Although, more recently, State-operated psychiatric centers have filed about a thousand new reports, in bulk, into the system, a very small percentage of the reports, about 5 percent, actually come from outpatient providers, and an insignificant number are being received from private practitioners.

Until recently, DCSs have passed on to DCJS about 90 percent of the reports that they have received, but most recently, some issues have come to our attention which are troubling, and have made many DCSs very skeptical.

Those problems include the following:

One, some DCSs are receiving reports that appear to be made by someone other than a mental-health professional treating the patient.

This might be a person designated by the hospital to make such reports, or, even in some cases, by a computer-generated report coming out of

the admission -- the Electronic Health Records System.

Technically, we believe such report is not appropriate under the statute;

Secondly, there is a great deal of confusion about the intent of the statute as the language was somewhat unclear.

For example, for some period of time, the State took the position that all persons admitted to a State psychiatric center met the criteria of 946 simply by virtue of their admission.

And for at least some period of time, all such admitted persons were apparently being reported en masse by computer-generated reports.

This is not even consistent with State Office of Mental Health's published guidance, which has indicated, that even though a person could meet the 2 PC standard, the normal standard for admission on an involuntary basis, they might still not pose a risk of harm that justifies reporting under the 946 standard.

Groups representing the Article 28 hospitals have indicated to us that they are also concerned with this procedure, and we all agree that not all persons admitted for mental-health treatment meet

the criteria of 946.

It would have been useful for those of us who deal with this system every day to have been called upon for advice in drafting the language of statute, and we remain available if changes are to be made;

Three, we are advised that, in some cases, based on the potential risk -- based on potential risk-management standards, hospital administrators or hospital counsel have recommended or required that all persons admitted to hospitals with a mental-illness diagnosis be reported under 946.

In passing on a 946 Report, a DCS is required by the law to make a judgment, which involves weighing what is essentially an invasion of a person's civil rights just because they're mentally ill, against the legitimate need of the State to protect the public.

The statute requires that this judgment be based on a reasonable professional judgment, and should be made on a case-by-case basis by a trained professional who is treating a person.

Someone being admitted to a hospital merely because of their inability to care for themselves due to a mental illness or for medication management is not, in most cases, likely to meet the criteria

of the statute.

In some cases, the numbers of reports are simply just too staggering for any independent evaluation to occur, so the DCS is required by reality to accept the validity of the ISARS report.

Some DCSs are concerned that, in such cases, it is possible that persons who do not meet the requirements of the statute are being reported on to DCJS, but without adequate resources, there is little that we as DCSs can do;

Four, the statute, as written, contains no specification regarding the age of a patient to be reported.

Recently, DCSs have begun receiving numerous reports, primarily from State hospitals, which involve children who are as young as 11 years old.

Upon investigation, we determined that the State Office of Mental Health is requiring all of its hospitals, and advising Article 28 hospitals, to report admissions of all 11-year-old children or anyone older.

We are told that this is because, theoretically, it is possible for a 16-year-old to enter into military service with parental consent, and to be potentially discharged, also at age 16,

and then apply for a gun permit.

And as you know, under Penal Law Section 400, the age requirement for veterans is waived, and the name remains in the database for five years.

So, therefore, 16 minus 5 is 11, so they've begun reporting 11-year-olds.

Many members of The Conference feel that placing the name of an 11-year-old emotionally disturbed child into what is, essentially, a criminal-justice database, is, in and of itself, unconscionable.

But, to determine that the benefit of the unlikely possibility that there might be a 16-year-old who had been emotionally disturbed at age 11, and then managed to enlist in the military at 16 with parental consent, and then was also discharged at 16, because of some unknown reason, might get a gun permit, is just, in our opinion, it defies logic.

The Conference has written to Commissioner Woodlock, outlining these issues, and we expect to be meeting with her and her staff in the near future to discuss and, hopefully, resolve these issues.

We would also hope that the Legislature would

alleviate and correct this egregious practice;

Lastly, our members feel that the greatest problem that we have with the SAFE Act is that it is simply diverting too much time and resources from other duties of the DCS for what we believe to be a minimal return.

We are told that of the 6,000 reports that have been filed, 11 have resulted in action.

And we believe that the amount of time and energy involved in that, for people who would probably have been found out during the appropriate investigation, is simply not worth the diversion of resources.

The large numbers of 946 reports are diverting substantial time and energy away from an already overburdened staff.

New York City alone has filed -- has received over 3500 such reports already.

And in other larger counties in the state, such as Syracuse, the range of reports are 50 to 100 reports per week.

Given that people who apply for gun permits also have to undergo a formal investigation, we believe that this is just simply not a good use of what are, essentially, mental-health resources for

criminal-justice purposes.

And, finally, as a lawyer, and former counsel to a legislative committee on mental health myself, I cannot close without at least pointing out some of the problems that I perceive with the statute, as written:

First of all, the law defines "mental-health professionals" as including all physicians and all registered nurses, and does not require that the mental-health professional actually be treating the subject for a mental illness.

While we are interpreting it as such, it is possible that some court might not.

And as the law was written, any physician who is treating any patient for any reason, who determines that the patient may be likely to engage in dangerous conduct, could -- should be reported.

Theoretically, therefore, a dermatologist who is treating an 11-year-old for acne, and is told by the patient, "I hate my skin so much that I could kill myself," could, in fact, be required to file a 946 Report.

And this, of course, makes no sense;

Secondly, the law does not say that the likelihood of the danger must be imminent.

As you know, all the other provisions of Article 9 of the Mental Hygiene Law that allow the limitation of another's freedom, provide that there must be some immediate danger to self or others.

And, here, the standard is only "likely to engage in conduct."

Now, does that mean tomorrow? next week? next year?

We have been interpreting it as meaning immediate, but a court could undoubtedly interpret it otherwise.

Indeed, the court of appeals has held that the fact of mental illness does not result in the forfeiture of a person's civil rights.

The courts will, of course, have the final say, but I question whether placing someone's name in what is, essentially, a criminal-justice database, based on the SAFE Act standards, meets the test, especially when the person is 11 years old.

The statute specifically limits liability for the mental-health professional with regard to reporting, but there is no such limit on liability for the DCS or the local government in making reporting decisions in good faith.

And we believe that that should be corrected;

And, finally, from the point of view of government -- a local government, Section 946 is simply another unfunded mandate of a growing and potentially disastrous magnitude for which localities are neither equipped nor funded to implement.

If the statute's intent is simply to gather names, then why have the DCS involved in the process at all?

If the intent is to really clinically assess each of these 6,000 reports, then either that should be done by a state agency, or substantial resources must be allocated to local governments to do it.

Since all gun-permit applications, as I said, require investigation, we believe that this is casting such a wide net, when it appears to criminalize people simply who are suffering from mental illness, and increases the very stigma which we are all so hard trying to decrease.

So on behalf of The Conference of Local Mental Hygiene Directors, I want to thank you all for your efforts on behalf of the mentally disabled of the state who depend on us to help them go forward toward recovery, and for the opportunity to share The Conference's views and perspectives on the

SAFE Act with you today.

As always, The Conference remains available to you as a resource as you continue your work.

Thank you.

SENATOR CARLUCCI: Great, thank you, Mr. Wolkenbreit.

Just a few quick questions, because the testimony was pretty thorough, and I appreciate that.

You talked about the 92 percent of the reports are coming from hospitals.

And, what do you attribute that to?

JED WOLKENBREIT: Well, we've heard -- and although this is all anecdotal, of course, we've heard there's a substantial reluctance amongst private practitioners.

I think, initially, there was not a lot of knowledge on the part of many people that this reporting requirement even existed.

I think that's becoming less of an issue.

But I think that there's -- that hospitals clearly have the apparatus involved to have explained it all to their physicians.

Hospital counsels are on it, obviously.

There's numerous organizations and

professional groups that have made that clear.

I think there's a lot of mental-health professionals who firmly believe that, in treating people on an outpatient basis, if they can handle it on an outpatient basis, by definition, the person is not really dangerous enough to require a report.

And I think there's a lot of reluctance upon professionals to have the professionals get involved in reporting, effectively, somebody to the police, and merely because they're mentally ill.

SENATOR CARLUCCI: Now, has your organization run some numbers in terms of, when we talk about the mandated costs on local governments, what you anticipate that this could cost local governments?

JED WOLKENBREIT: We did a study initially. We anticipated it was about $11 million that it's going to cost state governments.

And it's really become, you know, the problem is, if you were to really review every report, it would probably be more than that.

I mean, the fact that the State has, you know, created the ISARS system has helped substantially, and we're very thankful for that. And I've commended them on numerous occasions, publicly.

But, you know, it still requires the DCS and/or his or her designee to sit there and go through these things, or -- and that's not going happen.

If you get 3500 reports, I mean, it would require more staff than the mental-health department has to -- you know, full time to be doing it. And it's just not going to happen.

SENATOR CARLUCCI: In the -- out of the 6,000 cases that we're talking about, and the 11 actual cases that have come forward, could you elaborate on those, what those were, a little more?

JED WOLKENBREIT: I haven't -- I don't -- I've only gotten the statistics.

SENATOR CARLUCCI: Right.

JED WOLKENBREIT: I have no personal knowledge.

SENATOR CARLUCCI: Have you seen, have you gotten real information, in terms of, like, you talked about the hypothetical case of the dermatologist reporting someone?

Has there been any validity to that?

JED WOLKENBREIT: I don't think -- well, there hasn't actually -- nothing that -- I mean, I'm obviously exaggerating the point to make a point,

but, I think what has happened, in many cases, though, is that, reports have been made of people, because I think some mental-health professionals who work for hospitals or for other, you know, entities have been advised, basically, for the liability purposes, that they have to report, so they're reporting, when, in their own professional judgment, it might not be appropriate.

And we have been told -- or, DCSs have been told, in checking some of these reports, when they've talked to the professional, and they call up and said, "Why did you file this report? It doesn't look" -- I mean, for example, just because somebody had suicidal ideations does not necessarily mean that they're dangerous, or that they're going commit suicide.

And, you know, the professional would admit, "Well, I don't really think, but I'm concerned not to do it." And they're sort of being pushed into making those reports.

SENATOR VALESKY: Just a couple quick questions for you, and thank you for your testimony.

Is The Conference in any way engaged in, or considering engaging in, drafting any potential changes to the law?

JED WOLKENBREIT: We have suggested language to both Houses of the Legislature and to the Governor's Office, and at this point, we're being told that no changes are being considered.

So, I haven't heard anything back.

SENATOR VALESKY: Okay.

The other thing that you mentioned in your testimony, you remind us that the court of appeals has held to the fact that mental illness does not result in the forfeiture of a person's civil rights.

There are, obviously, a number of high-profile court challenges right now to the SAFE Act, based on other components of that law.

Are there any legal challenges to this particular section of the SAFE Act?

JED WOLKENBREIT: I'm not aware of any.

SENATOR VALESKY: I'm not aware either, but I --

JED WOLKENBREIT: I'm not aware of any, at this point.

SENATOR VALESKY:

Okay, thank you.

SENATOR CARLUCCI: All right, thank you.

JED WOLKENBREIT: Thank you.

SENATOR CARLUCCI: Next we're going to hear from Dr. Glenn Martin, and Seth Stein.

Dr. Martin is the president of the New York State Psychiatric Association, and Mr. Stein is the executive director.

Thank you for being here today.

DR. GLENN MARTIN: Thank you for having us.

So, Senators, thank you for the opportunity to offer testimony regarding the mental-health reporting requirements of the SAFE Act.

As you know, my name is Glenn Martin. I'm a practicing psychiatrist, and the current president of the New York State Psychiatric Association, which I'm representing today.

Joining me is Seth Stein, our executive director, and general counsel.

Just, New York State Psychiatric Association is a statewide medical-specialty organization with over 4,000 psychiatrists in New York State.

And as requested, we e-mailed our testimony to you on Wednesday.

I'm also appearing today on behalf of the Medical Society of the State of New York, where I serve as Chairperson of the Committee on Addiction and Psychiatric Medicine Committee.

I'm pinch-hitting for the MSSNY president, Dr. Sam Unterricht, who, unfortunately, can't be with us today.

Dr. Unterricht's written testimony has also been submitted.

And, I think I'll spare all of us, and if you permit, rather than reading the testimony from both, I would prefer to speak extemporaneously, which may be a problem, but -- it won't be a problem to speak, but it may be a problem once I get started.

So what I would like to point out is, first of the all, the New York State Psychiatric Association and the American Psychiatric Association clearly recognize that gun violence is a public-health concern.

It is, with suicide actually being the more important concern, from our point of view, in the sense that many more patients with mental illness are going to die as a result of suicide from guns than they are going to either commit or be a victim of violence.

In fact, all studies will show that you're much more likely, if you're mentally ill, to be a victim of violence than a perpetrator of violence.

And, in fact, a number of diagnosed mentally

ill who are involved in violent crimes totally comes down to about 2 to 5 percent, depending on what you're doing.

This is not a huge number. It's certainly very headline-grabbing when it occurs.

And, unfortunately, the focus on this is what leads to my first concern, which is the stigma associated with singling out mental illness for doing -- for making reports, as well as the concerns we have about confidentiality.

Now, clearly, our profession has always understood that protecting patients from mental illness, and those around them, is an important part of what we do. And we have never advocated for an absolute privilege of confidentiality.

And the State, and the government in general, has understood, though, that it's absolutely crucial that we do have a great deal of leeway in confidentiality in order to do our jobs.

People are not going talk to us if they're worried that we are going to rat them out at a moment's notice.

There are other professions that also have this.

For example, the clergy and lawyers also have

pretty absolute confidentiality.

I will just mention, parenthetically, and probably not politically correctly, that they're not obligated to report dangerous behavior when it comes to their attention.

And I would imagine that many lawyers have been faced with situations of people coming into their offices who they believe are dangerous to others, either because they're professional criminals -- innocent, of course, but professional criminals -- or, in a divorce proceeding, or something, would say something that would make them dangerous, and the State is not mandating them to do anything to violate their confidentiality;

Nor priests, or the like.

But I'm saying, we are used to doing this, but, what we're used to doing is more what's in 3113 of the regulations, where it allows people who work in OMH to either, basically, hospitalize a patient who is dangerous, or, arrange for the police to be notified to protect somebody, or, notify the person who is the direct likely victim.

That's not mandated. It's left in our judgment to decide whether or not we're going to do that.

And as has been pointed out by the previous speaker, in fact, the changes to the law don't allow us to do that. It tells us we are supposed to -- actually, it doesn't say anything about going online, or anything else.

And let me just say that we applaud OMH's effort to try to interpret what the legislation says, but, in fact, what they've done isn't what the legislation says.

The legislation refers to "likelihood."

I can either argue that everyone is likely to be violent at some point.

My children would argue I can do that to them in a matter of moments, if I try.

On the other hand, no one is particularly likely of being a violent. Unless you're a professional hitman, it's a relatively rare event.

"Likelihood" isn't a standard that we work with.

"Imminence" is something we can understand.

Also, we are not very good at protecting -- predicting violence in any particular period of time.

Short term -- and I ran a psychiatric emergency room for eight years out of Queens when it

was really hopping -- we were pretty good, or we like to think we were pretty good, at determining whether or not somebody was likely to be violent in the near future, imminently.

There are other people who, I had a pretty good chance, were going to end up dead at some point in their lives, but I didn't think it was going to be imminent, and we would let them go and arrange for outpatient care.

This standard doesn't make a huge amount of sense.

And, frankly, as the previous speaker pointed out, it's sort of a mix between trying to identify people who you think shouldn't have guns, and at the same time, not giving us the legal authority, essentially, to break confidentiality.

There's nothing in this statute that let's us do what we would want to do, when we need to do it.

So, we have, in fact, worked, and suggest that there are some changes to the law that we think will make it better, because we do understand this is an important public-health issue.

We do believe that "imminence" should be included in this statute; that it should be a short-term defined period of time.

Also, I point out that OMH has decided that substance abuse is not a psychiatric disorder, which is interesting to me, because, certainly, in DSM-5, which you may have heard we just published, we did not remove all substance abuse from our manual.

We do consider that part and parcel of what we do for a living, frequently comorbid with other disorders, but, they have taken the role that pure substance abuse, whatever that is, is not reportable, even though those people might be even more likely to be imminently dangerous.

They also don't necessarily allow us to report pure criminal behavior.

I mean, frequently, we see people in the emergency room who had gotten into a fight, and have basically said: I'm going to go back, you know, and get the guy who punched me out at the bar.

He's sober now. He is going take vengeance.

That's not a mental illness, necessarily, but he sure as heck is dangerous, in my judgment.

It is unclear whether we're supposed to report or not.

OMH says no, but the statute is unclear.

And, as much as I agreed with virtually everything the previous speaker had said, I thought,

actually, his example of the dermatologist is an interesting one.

Change it to a 35-year-old man or woman with horrible skin disease who's on a medication that can cause depression, of which some of theirs can, comes in and says: I really can't stand living like this anymore. I've been thinking about ending my life.

Would you not think that that is a professional stance that they should do something about it, and why would you precludes that person from doing it?

So in this great fog of uncertainty, as the previous speaker pointed out, you have the risk-management approach: "report everyone," to the, "I don't want to report anyone confidentiality" [unintelligible].

And I think as he said, the idea that most of your reports coming out of the hospital makes sense.

If you really think somebody's imminently likely to hurt themselves, and they're in your office, you will take steps to get them into a hospital, and probably let the hospital do the reporting for you.

If you don't think they're imminent, even though you think that they're, you know, possibly

going to end their life, because they have a bad personality disorder with chronic depression, at some point it may end badly, but you're doing your best to try to avoid it, and hospitalization isn't going to add anything right now, you may decide not to do that;

The second issue is, who to report to.

As mentioned, we have this convoluted thing where, theoretically, I could report it online.

The -- interestingly, when you go online now, it flashes to you: Imminent danger, call 911. Imminent danger, call 911.

But calling 911 isn't good enough, because I still have to make this report.

I would argue that, frankly, you should allow us to do what you allow OMH-licensed facilities to do, which is, call 911 and say: I have a patient who is in danger, or dangering somebody else. Please send the police to safely escort him to an emergency room where he can be treated.

And then they can do all the reporting they want.

Confidentiality becomes less of an issue. There's already a police report, there's an ambulance call report...all of this is done.

And I would mention, on the back end, the reporting is going on right now anyway.

All involuntary hospitalizations have to be reported to the federal database to be checked against.

So, again, from a confidentiality point of view, that's already occurring;

Thirdly, the liability issue, which was raised from a DCS [unintelligible]. They're not covered at all.

I have to say that, as a practicing physician, I'm not particularly thrilled by the language that is used about "good judgment," because good judgment can always be questioned, especially through the retrospective scope by another expert, three months after the fact, where something bad happened, you can say, Well, obviously you showed bad judgment.

I believe that organized medicine would be much happier if we used "malice" or "intentional misconduct," which is the standard that already exists in statute, and I think would do what's necessary to allow us to do this;

And then, lastly, I would just point out what the previous speaker had mentioned, about the scope.

Nurses, to my understanding, other than nurse practitioners, are not in a position where they can diagnose or treat or prescribe.

So, why they have this mandated obligation to do something that the government, in its wisdom, has not given them the scope of practice to do, doesn't make a huge amount of sense either.

So...

All right, I'll shut up, and answer any questions, if there are any.

And, again, as I said, so those are the four major points that we've made.

And as I said, Assembly Bill of A6233 has some of the language already incorporated.

UNIDENTIFIED SPEAKER 1: The Pretlow bill does?

UNIDENTIFIED SPEAKER 2: Yes.

DR. GLENN MARTIN: Yeah.

And, of course, we stand ready to cooperate with anyone who is willing to listen to us.

SENATOR CARLUCCI: Just one question about, with HIPAA, in terms of, as a professional, in your role, what happens when state law contradicts HIPAA?

DR. GLENN MARTIN: Well, almost by definition, it can't, in the sense, that the most

restrictive -- the -- HIPAA is always a floor, not a celling. And that if the State is more restrictive, you have to follow the state law.

The state can't be more permissive than HIPAA.

So, in fact, we have filed an inquiry, or complaint, with the Office of Civil Rights, because we believe, in fact, this is not compliant with HIPAA, because of the lack of imminence, in particular, as well as some of the subtleties about the mandate, and what you do and don't have to do, that it's actually not compliant with HIPAA right now, which does not make, you know, many of us particularly happy when we have to do this.

We have had no problem, from a HIPAA perspective, if there's an imminent risk, you know, basically, all bets are off. We do what's necessary to do, to protect the patient and protect the potential victim.

Again, the intent of this law is not to do that.

I mean, the intent of this law is to remove firearms from people with mental illnesses who have a likelihood of dangerousness for approximately five years.

I know OMH, just in some of the talks they mentioned, when they talk about the 11-year-old, and that rather convoluted theory about them joining the military, you know, is I do believe that there is something in the law that will go into effect about purchasing ammunition, as well as requiring the owner of a firearm, that has somebody in the household who is not allowed to have a firearm, to properly secure it.

So you can argue, again, that reporting children in that context, may not be quite as silly as it sounds with their other argument about joining the military, and leaving, blah blah blah blah.

SENATOR CARLUCCI: Just one other part, in your -- in the written testimony that you submitted, you had mentioned the required-by-law exception under HIPAA.

DR. GLENN MARTIN: Right.

SENATOR CARLUCCI: And, could you just elaborate upon that?

DR. GLENN MARTIN: If you don't mind, that becomes technical enough --

SENATOR CARLUCCI: Go ahead.

DR. GLENN MARTIN: -- and I'll allow --

SETH STEIN: Well, our HIPAA argument really

is two sides:

HIPAA contains an authorization to disclose confidential information in this scenario, but it requires that the circumstance be an imminent danger to self or others, and, that it be to law enforcement or an identifiable victim.

So, HIPAA authorizes that.

Then there's a section on mandates.

And it could be argued that the SAFE Act isn't a mandate at all, because it looks like a mandate, but when you examine it, you could compare it in New York to the child-abuse reporting requirement. That's a mandate, and it has a misdemeanor attached to it if you don't do it.

And this -- so this is neither an authorization, exactly, or, a mandate. It sits kind of in between.

And that's the reason why we pursued this with the Federal Office of Civil Rights, because we said that it's neither -- it's neither of the two; and, therefore, a doctor who is compelled -- perceives themselves to be compelled by the SAFE Act could be construed as violating HIPAA.

And we felt that you could be caught between the two different state and federal law.

And as Dr. Martin said, HIPAA makes it quite clear that it is -- that it only will yield to state laws that are more stringently protecting privacy.

And in this -- so, therefore, it would not yield to the SAFE Act, because the SAFE Act does not provide more stringent protections of privacy.

In fact, it weakens it, from the HIPAA's perspective.

But I think the solution to that, that we've suggested, and that's reflected in the Pretlow bill, is simply to put in this 3313 standard -- 3313(f) standard -- (6) standard, which says, "imminent risk of serious harm to self or others," right, and make it an authorization statute, right, and change the "exculpation" language to mirror 3313.

In other words, it's right there.

In fact, just, ironically, I believe that the HIPAA section on "Authorization" was based on New York State's 3313; in other words, it almost tracks that language, and why.

So that we feel the simplist solution, is to track that language.

And if the Legislature, in its wisdom, still wants the reporting, in addition to police, and

identifiable victim, and in addition, the gun thing, to go on, rather than have the police do that, which, it seems to us, to be a far more logical thing.

In other words, if they -- if a psychiatrist calls up the police and says, "I'm worried about this individual," right, the police are in a much better position, quickly, to ascertain whether that person has a licensed or registered firearm than anybody else has, instantaneously, even before they go to the apartment or to their residence, to ascertain whether they have a firearm at that location or not.

Which I assume would be a prudent step to take.

And what we pointed out in the statute, is that the process now, right, of that whole long circuitous process to get to the Division of Criminal Justice Services, doesn't really intervene quickly, when that's really what should be taking place: a quick intervention, based upon an imminent risk, and an assessment of whether the individual possesses a registered or legal firearm before the police go and knock on the door, to inquire as to what's going on.

SENATOR VALESKY: Can I just get a point of clarification on your comparison between this and the child-abuse reporting?

The result of a lack of a penalty, that's why this would not be considered a mandate?

Is that what you said?

SETH STEIN: Yeah, because it's really, when you look at the statute carefully, it's not -- it doesn't have the same -- it doesn't say -- it's not really a "must" statute, because the federal HIPAA law says that a mandate must be associated with a penalty for failure.

And there really isn't any penalty under the SAFE Act, so, it looks like a mandate, but isn't really a mandate.

But as we heard from the first -- you know, from the Local Mental Hygiene Directors' counsel, it's being interpreted, and overinterpreted, as a super-mandate; in other words, they're reporting anybody.

I mean, they're not even -- in other words, because, why not? Why not do it?

And I think that's why the "exculpation" language, if it copied 3313, people would feel more comfortable exercising, what Dr. Martin said, is

that professional judgment, and weighing whether or not.

Because even -- I mean, it could be argued, and we thought originally, before OMH came out, that a person who is involuntarily hospitalized, right, where they can't leave, is a person for whom, otherwise, no report.

In other words, the police wouldn't be called if someone was involuntary hospitalized, right, unless they eloped, or something like that.

But absent that, they're safe.

But if the safe -- but, you know, that's -- but we came to realize that OMH intended, actually, we said in our testimony, they were even talking about reporting on discharge, let alone reporting on admission.

So that made no sense to us, because how would could someone be danger to self or others, unless you're talking about, could they possibly be at some time in the remote future, right, if their symptomatology returned, and so forth and so on.

And if that -- and that's exactly what they meant.

And it seems to me, is that that gets beyond the scope of what's reasonable, or useful.

SENATOR VALESKY: Thank you, both.

SETH STEIN: Thank you.

DR. GLENN MARTIN: Thank you.

SENATOR CARLUCCI: Thank you, Mr. Stein.

Dr. Martin, thank you.

DR. GLENN MARTIN: Thank you for having us.

SENATOR CARLUCCI: And our next speaker is from the New York Association of Psychiatric Rehabilitation Services, or, "NYAPRS," Carla Rabinowitz, who's the public-policy chair.

CARLA RABINOWITZ: So thank you for this opportunity to present the concerns of thousands of New Yorkers represented by NYAPRS, the "New York Association of Psychiatric Rehabilitation Services."

NYAPRS is a unique partnership of people with psychiatric disabilities across the state and the mental-health professionals who support us.

So, I'm Carla. I'm the co-chair of NYAPRS's Public Policy Committee, and today I'm also representing NYAPRS's executive director, Harvey Rosenthal, who apologizes, but was unable to be here because he had a previous out-of-state commitment.

I also work for, get paid by, an organization

called "Community Access," which I'm plugging, which is a 39-year-old organization that empowers mental-health recipients in many ways, by providing quality housing, and employment, for people with mental-health concerns.

So, State mental-health policy is a very personal matter to NYAPRS. It's a personal matter to NYAPRS's organizational members. It's a personal matter to the board members, to the staff, the mental-health recipients, and to myself, as we -- most of us all share some type of psychiatric disability.

So Harvey and myself would like to begin by focusing on the media coverage: what's been happening, and how this all came to be.

So you know about the horrific media coverage, the demonization, the criminalization, in the minds of people of mental-health recipients, due to the -- in the wake of the recent tragedies in Newtown, New York City, and elsewhere.

Now, these tragedies are abhorrent.

They are especially abhorrent to the mental-health recipients, because, as other speakers have said, we're more likely to be victims of crime, twelve times, and we're five times more likely than

the general public to be murdered.

But there's no studies that are showing, despite all the stigma, that we're more likely to be violent.

There is some association and some studies with substance use and violence, but that applies to everybody in the general public, not just mental-health recipients.

Despite this, and, you know, as people, these horrific act of violence are often associated with mental illness, and we get demonized in the mental-health community.

An example is, the "New York Post," where -- when they talked about releasing people, reinvestment, releasing -- releasing people from psychiatric hospitals that weren't serving them well, the headline was, "11,000 psychotics on the street."

Or, you know, the headlines such as that.

And it's -- and if you look at what "The Daily News" found, which isn't always the greatest, but "The Daily News" said they did a study of what happened in 2007. They found that, of 500 murders, only 5 were by mental-health recipients.

Yet, those five were probably in the news for months; right?

And the stark truth is, that the public doesn't need protection from people with mental-health concerns.

It's us who need protection from this outrageous mischaracterization, and from the rush to enact laws that provides false solutions to appease public fears: this violence occurred, people got afraid, elected officials representing the vast majority of people who don't have mental-health concerns said, Let's pass this law without concerns for the mental-health recipients.

So we at NYAPRS applaud the State's acts -- attempts to reduce gun-related violence, but the requirement that mental-health clinicians report clients who disclose impulses to harm themselves or others is really, really problematic.

Some of the things that haven't been talked about is the chilling effect that it's going to have with mental-health recipients and therapists or psychiatrists.

You trust someone. You think about it, if you were talking to a priest and you told him some confidential secrets, and then you found out he

disclosed it to the State, you know, there goes the relationship.

And you can imagine that -- you know, you've heard from the APA and others who are concerned about that.

So we think that this reporting requirement really intrudes in a client-patient relationship, and that's just a mild way of saying it.

It's, like, people -- let's say you were in the Army, and you have PTSD. You know, you might have thoughts of violence.

Are you going to keep on going to your therapist? Are you going to stop what you're saying to your therapist?

And then it's less helpful, and the psychiatrist is less helpful, and maybe you don't get the medication you need, because you're not saying the truth.

Also, clinicians don't have the ability to predict future violence, as this man from the APA was saying.

We have a study here, but there's other better studies from the APA that basically says they can't predict future violence, they just can't, amongst anybody.

And as was said, our real concern right here is that the SAFE Act, using this broad language, right, "likely to engage in conduct that will result in serious harm to self or others," and nobody knows what that means. Right?

So some may underreport, and some may overreport.

We need to get back to the "serious and imminent danger threat" standard.

And a type of technical amendment was proposed this past session by someone named "Pretlow."

And you have the citation here, the statute, the bill, A6233. He's from Mount Vernon, Pretlow.

And it basically, you know, clarifies what triggers a reporting by professionals to this imminent danger.

And I just want to conclude by thanking you for your time, but just to let you know that, you know, I myself am a mental-health recipient. And, I got my license back by proving that I was going to treatment, and such, my law license.

And in today's world, I don't know if that would happen.

You know, there's a lot of hysteria going on,

and that's how this law came to be. And we need to tailor it a little bit more to what would really work, and what would not destroy a relationship with therapists and psychiatrists.

SENATOR CARLUCCI: Carla, thank you so much for your testimony.

And it's a very important and serious issue in terms of the stigma, and it's something that we do have to fight against.

And, I appreciate your testimony and some -- the written testimony, specifically, and some strategies to do that.

I just was at a Veterans' Advisory Committee meeting, and we were talking about PTSD and the stigma attached to that.

And, you know, we talk about it. And I don't think I even have to ask about your feelings on people not going for the treatment that they need out of fear of this stigma.

So, we have something that we definitely have to work towards, and appreciate your work in that area.

CARLA RABINOWITZ: Narrow it down to [unintelligible], like everyone's saying.

Thank you.

SENATOR CARLUCCI: Thank you.

SENATOR VALESKY: Thank you, Carla.

SENATOR CARLUCCI: Next we have Mary Beth Anderson, who's the project director of the Urban Justice Mental Health Project.

MARY BETH ANDERSON: I want to thank you so much for scheduling me early in the day. Sarah from your office agreed to do that, as I do have another meeting to go to.

And my colleague Megan Crowe-Rothstein, who is our director of social work, will remain throughout the hearing.

And I do echo many of the comments made by Dr. Martin regarding the statistics on people with mental illness and the tenuous connection to violence.

I also echo the concerns of Ms. Rabinowitz.

I agree completely that the major problem, in my view, with any connection between violence and mental illness, is that there is still so much stigma attached to having a mental illness and receiving mental-health treatment.

And, I think that ways to -- finding ways to decrease this stigma are really essential in order to help people with mental illness access treatment.

I won't reiterate my written testimony, but just highlight a few things that are contained in it.

New York State has one of the lowest levels of gun violence in the entire country. It seems to be within the bottom five in any study that's been done, and there have been a lot of studies done.

And I do believe this is largely due to our strong gun-control laws.

The Urban Justice Center Mental Health Project provides direct legal and social-work services, and we do impact litigation, to try to help people with mental illness receive treatment, live fuller lives.

And we have had clients and prospective clients come in and tell us about their concerns about the SAFE Act.

And we certainly know that one of the greater problems for some people to access treatment, is paranoia about being included on some sort of government list.

The SAFE Act just increases that paranoia.

And what -- in addition to increasing the stigma, we feel that there are particular classes of people that will be inhibited.

We echo Ms. Rabinowitz's concern about veterans being unwilling or reluctant to access treatment.

And I also know members of law enforcement would have great difficulty. I mean, most members of law enforcement are licensed to carry guns, and I think that this will inhibit them.

And, in fact, I've talked with three different groups of law-enforcement officers in the past month, and all of them felt that the SAFE Act did not assist to make -- to meet the aims.

What's really of concern to me, is we had a real tragedy that propelled the enactment of this law, but the tragedy likely would not have been prevented by the enactment of this law.

So if this type of legislation had existed in Connecticut, in Colorado, in Arizona, in any of the places where we've seen some tremendous mass shootings in the past couple of years, I don't believe that it would have prevented any of those incidences.

My experience in dealing with people with mental illness comes primarily through 20-plus years of work as a public defender, where I spent the last 15 years of my work really concentrating my practice

around trying to help people with mental illness who get caught up in the criminal justice system, to get out of the criminal justice system.

I did this at the Legal Aid Society of New York, and, at Brooklyn Defender Services, in their criminal practices.

And I have worked -- even before I became the director of the Urban Justice Center Mental Health Project, I have worked with the Mental Health Project to try to improve the lives of people with mental illness who get caught up in the criminal justice system here in New York City, and who receive mental-health services in the state prisons.

By and large, people with mental illness that do commit crime do not commit violent crime.

And, the violent crime that's committed is generally not gun crime.

And when guns are used, they are almost always illegally possessed.

And, I forget whether it was the first speaker or Dr. Martin who talked about, that there have only been, out of some thousand -- 5,000 reports, there have only been 11, or, 3,000 reports, 11, founded circumstances where there were guns involved.

The vast majority of guns that people -- any people in New York use to commit crimes, are illegally possessed.

And I just don't think that there's enough of a connection between gun crime and mental illness to justify this reporting, which so, so increases discrimination against people with mental illness.

In addition, there is just one other item that I would like to highlight.

I find it almost beyond belief that there's a mandate for people who are released from state prison to psychiatric -- local psychiatric facilities to be mandated for assessment for assisted outpatient treatment.

In my view, I know that assisted outpatient treatment is used far more frequently downstate than upstate, and maybe there is a need to try to help people who are eligible upstate, to have clinicians refer eligible people.

But, I think that it's just flat out wrong, and clearly discriminatory, to say: If you were in state prison, and you were discharged to a psychiatric facility, you need to be assessed for AOT before you can be released to the community.

There is really -- while many of those people

may meet the criteria for AOT, the ones who meet the criteria for AOT should be referred if it would be helpful and of benefit to them.

One of the criteria for AOT, is that the order would be a benefit to the respondent of the order.

So, if they meet the criteria, and the order would be of benefit, they should be referred, but they should not be referred for assessment merely because they happen to be caught up in the criminal justice system.

Thank you very much for giving me this opportunity to testify today.

SENATOR VALESKY: We thank you for your interest, and your work in the field.

Thank you.

MARY BETH ANDERSON: Thank you.

SENATOR CARLUCCI: Next we're going to hear from Jason Lippman, who's the senior associate of policy and advocacy for the Coalition of Behavioral Health Agencies.

JASON LIPPMAN: Good afternoon, Senator Carlucci and Senator Valesky.

Thank you for allowing me the opportunity to testify before you today.

The New York SAFE Act, as it relates to mental-health services and mental-health-professional reporting requirements.

Before I address concerns about the SAFE Act, I thought it is important to point out that, as has been mentioned by other speakers, that the link between mental illness and violence is a serious one.

Each year, 20 percent of Americans suffer from a mental illness, and almost half of Americans experience some form of behavioral health symptoms throughout their lives; yet, when it comes to incidence of violent crimes, only a very small portion, about 4 percent, are committed by individuals with mental illness.

In addition, individuals with mental illness are 12 times more likely to be victims of crime, as you heard earlier as well.

More reliable predicters of violence include things like age, gender, prevalence of substance abuse, disorder, and the nature and quality of one's environment, and past behavior.

Misperceptions about people with mental illness can lead to discrimination and hinder recovery.

Such stigma also deters people with mental illness from seeking professional help.

The coalition actually supports provisions in the SAFE Act related to gun control.

Specifically, we support the expanding of New York's laws to ban assault weapons and high-capacity magazines, as well as expanding background checks on sales and purchase of firearms for all New York State residences.

We believe that gun control is a significant public-health issue.

We are concerned, obviously, about the SAFE Act's requirement that mental-health professionals have to report.

We believe that it not only stigmatizes people with mental illness and deter them from treatment, but it is also in violation of HIPAA, as you heard earlier, and because of that, it exposes practitioners to liability risks.

It is current the case that the HIPAA law allows practitioners to report clients in the presence of an imminent threat, and to a person or entity that is reasonably able to prevent or lessen such a specific threat.

The SAFE Act does not meet this standard.

Furthermore, it creates an environment where individuals may not feel safe to speak freely or fully disclose their thoughts and feelings to mental-health professionals.

The HIPAA standard balances constitutional protection, personal safety, and privacy issues associated with mandatory reporting and database building, with the need to protect public health and safety.

Moreover, having two contradictory standards in place makes the SAFE Act's reporting requirements confusing and contradictory to follow.

Finally, rare acts of violence are usually carried out by individuals who are not in treatment.

We need to identify and engage them before crisis situations arise.

Preventive measures should include early identification and treatment for substance-abuse problems, more community behavioral health services, more screening and outreach engagement in primary care in schools, and more housing for people with severe mental illness and substance-abuse disorders.

On behalf of the 130 non-for-profit coalition members throughout New York City, Westchester, Rockland, and surrounding counties, we look forward

to working with you and members of the Legislature to remove this troubling provision, or at least tweak it in some way, while retaining the freedom to report that HIPAA allows.

I thank you for your time and interest, and I am available to answer any questions that you may have.

SENATOR CARLUCCI: Well, thank you very much.

You talked about the liability in terms of practitioners.

Could you elaborate on that a little bit more, in terms of what the fear is?

And, has there been some specific circumstances that you have seen in this case?

JASON LIPPMAN: I guess because the provisions in the SAFE Act are so vague, it leaves them open to interpretation in many different ways.

Also, in the SAFE Act, it lists four types of professionals that must report.

We've had questions from agencies: Well, what if someone else tells them?

I mean, that part I guess is kind of clearer.

But I guess, also, because it contradicts with the HIPAA standard.

It's hard to follow both at once. And if

you're caught in the middle, and you wind up in court, it leaves it open.

Stuff that are wide open, that the "likelihood" language, "using reasonable judgment," all of that was is open to interpretation.

And it's not just the practitioner itself. Also the provider agencies themselves would likely be open.

SENATOR VALESKY: Just a thought, I could have asked probably anyone who testified before: Are you aware of any similar reporting requirements in any other states?

JASON LIPPMAN: I am not.

That's a good question. And I think it's something I would like to look into.

So, I will, and I can get back to you.

And I'm sure other people would want to know.

We can do that too.

That's a good question.

SENATOR VALESKY: Thank you.

SENATOR CARLUCCI: Great.

Mr. Lippman, thank you very much.

JASON LIPPMAN: All right, thank you.

SENATOR CARLUCCI: Next we're going to hear from the New York State Psychological Association.

We have Dr. Eric Neblung, who's the president; and, Jerry Grodin, who's the director of professional affairs.

DR. ERIC NEBLUNG: Good afternoon.

Thank you very much for taking our testimony today.

Before I begin, I'd just like to say:

David, as a constituent, I'm very proud of the work you've been doing, and I'm very happy to be here with you today.

SENATOR CARLUCCI: Thank you.

DR. ERIC NEBLUNG: And, also, it's Dr. Grodin.

The New York State Psychological Association believes that the SAFE Act represents a sincere attempt to address the plague of gun violence in our state.

As such, we congratulate the New York State Legislature for taking on the hard task of reducing gun violence.

However, it is also our consensus opinion that the mental-health reporting provisions of the SAFE Act are not acceptable as they are currently written.

To be clear, these comments are limited only

to the mental-health reporting provisions of the act.

Regarding the act's mental-health reporting provisions, our opinion is based on the following conclusions:

First, the act's mental-health reporting provisions do nothing to allow a mental-health provider to take immediate action to deal with a dangerous mental-health patient.

By the very nature, the act's current mental-health reporting provisions are not designed to allow clinicians to breach confidentiality in a way that will allow them to take the necessary, direct, and immediate steps that will simultaneously help a dangerous patient and protect society from that patient.

Instead, the act requires the mental-health professional to make a report that must work its way relatively slowly through a bureaucracy.

The only possible result from this report, are the removal of licensed firearms or a restriction on an individual's ability to obtain firearms in the future.

The act does not provide for any other action; thus, it provides no assistance to

mental-health professionals who are dealing with immediately dangerous patients who may pose imminent threat to themselves or others;

Second, the act's mental-health reporting provisions are much too vague, and will lead to confused and inconsistent reporting.

Other jurisdictions that have tackled this problem have clarified the mental-health reporting requirements by specifying that the patient's threat of harm must be serious and imminent and involve threats of physical harm.

The addition of these terms "imminent," "serious," and "physical harm," would help mental professionals report only those patients who are clearly dangerous, and would prevent the expenditure of resources on investigations of a potential flood of vague and indefinite threats.

In addition, a clearly and specifically defined set of reporting criteria will limit the act's infringement on the confidentiality and privacy of persons who are not imminently and seriously dangerous, and would allow such persons to discuss their problems without fear of triggering a sudden and dramatic governmental intrusion into their private lives.

Thus, the clearer and more specific the mental-health reporting criteria, the less likely that the act will deter patients from seeking mental-health treatment, and the less likely that it will inhabit the honest disclosure of information during mental-health treatment;

Finally, the focus of the SAFE Act exclusively on the mentally ill, as opposed -- as potential sources of violence unnecessarily stigmatizes a part of the population that is much more likely to be the victims of, as opposed to the perpetrators of, violence.

Indeed, research suggests that the presence of mental illness only minimally predicts the commission of future violence.

Rather, there are other much more powerful predicters, most notably, active substance abuse, the presence of environmental stressors, and history of past violence.

We urge the Legislature to consider refining the act so that it more accurately and thoroughly addresses the factors that are known to raise the risk of future violence.

Thank you.

SENATOR VALESKY: I just wanted to follow up:

You, actually, in your testimony, have hinted at an answer to the previous question that I just asked.

You said, that, "other jurisdictions that tackled this problem."

Do you have -- what other jurisdictions are you referring to?

DR. ERIC NEBLUNG: There's other states that have looked into this issue.

California. Uhm...

Do you have some others in mind, Jerry?

DR. JERRY GRODIN: California, in particular, they were all struggling with this, and were much more specific in their definitions.

SENATOR VALESKY: Okay. So their statute -- from your perspective, their statute would be acceptable?

DR. JERRY GRODIN: It would be, because, I think that, for people in private practice, this is constructed in a way that is so non-specific, I think there would be great reluctance to actively report someone.

SENATOR CARLUCCI: Well, Dr. Grodin, Dr. Neblung, in the testimony, you did speak about

those specifics, and you mentioned them just now, and, we speak about these predicters of future violence.

Now, with these -- you know, with these predicters, are there ways that we could tailor the SAFE Act provisions that would address those predicters, and do it without further stigmatizing individuals?

DR. JERRY GRODIN: I think that tightening it up would make more much sense, so that it's more useable to people in private practice.

Because the private practitioner is going to feel like they're using what is called "their best judgment," the best judgment, based upon research, is:

Was the person under the influence of substances? No.

Was -- does the person have a past history of violence? No.

"So, you're basing your reporting based upon, what?"

And they would be very exposed under those conditions.

SENATOR CARLUCCI: Well, thank you so much.

We really appreciate the testimony, and look

forward to working with you in the future.

DR. ERIC NEBLUNG: Thank you, both.

DR. JERRY GRODIN: Thank you.

SENATOR CARLUCCI: Next we'll hear from Ari Moma, who is from the New York Nurses Association.

ARI MOMA, R.N.: Thank you, and good afternoon.

I appreciate your having us, the New York State Nurses Association, to present our testimony.

First, and foremost, I am a registered nurse.

I live in Brooklyn, and I work in Brooklyn.

And I'm here to speak on behalf of New York State Nurses Association.

We appreciate the opportunity to submit our testimony to this Committee.

The New York Association is the oldest and largest professional organization for registered nurses in New York State, and it represents the interests of more than 270,000 registered nurses in New York State.

I'm also the [unintelligible] collective-bargaining agent for more than 36,000 nurses, with 150 collective-bargaining facilities -- health-care facilities in

New York State.

Furthermost, I would tell you that nurses are front line. You know, we are in the hospital [unintelligible] we triage a patient and see them [unintelligible] first line.

And they experience the tragic effects of gun violence on a regular basis.

In my work on a psych unit --

I work in a psych unit at Interfaith Medical Center, and I've been a psych nurse for 17 years-plus.

-- and I've seen the effect [unintelligible] violence has taken on families, their loved ones, and community at large. And especially where I live, or where I work, which is [unintelligible] Brooklyn, I see it firsthand.

And most of the patients we have there are mostly classified as mostly forensic patients.

The New York Association will support the -- and we support and appreciate the effort to reduce the gun violence; however, we have serious concerns regarding the provision of the SAFE Act; specifically, the addition of Section 9.46 [unintelligible] of the Mental Health -- Mental Hygiene Law which establishes that the

mental-health-professional reporting requirements.

We appreciate the opportunity to speak with you, to be -- and hope to engage you as a panel in amending the requirement.

Mostly, before I continue, I will thank you [unintelligible] because, most of the time, we're in Albany, and we [unintelligible] New York has worked diligently to make most of the laws passed, especially the violence towards the nurses, which is the same [unintelligible] law that has -- it applied to the police officers.

So, with that, [unintelligible] you're going to work diligently to bring that concern, you know, to your -- you know, to the Committee -- to the full Committee.

The law we're talking about includes provision [unintelligible] mental-health professionals to make a report to local director of community services when the head [unintelligible] professional concludes, in their reasonable professional judgment, that the patient is likely to engage in conducts that would result in serious harm to self or others.

There are three concerns the New York Association has, and that is, [unintelligible] about

reporting requirement.

The first, and foremost, is the HIPAA.

Your reporting provision are not in compliance with the HIPAA standards;

Two, that the requirement that all mental-health registered nurses would be mandated reporters.

It's not consistent with current scope of our practice, and it poses us, the registered nurses, to liability;

And the third, the linking the gun-control efforts with mental health stigmatizes mental illnesses, and would create barriers to treating for individuals who would need it.

In elaborating those three points, the violation of HIPAA, as are groups that are testifying today, pointed -- some of the other groups pointed out earlier, that mandatory reporting requirement by the SAFE Act to a local director of community services constitute a violation of HIPAA, because SAFE Act, as presently written, (1) fails to require the presence of immediate threat as a precondition to release confidential health information, (2) it also fails to mandate the report that [unintelligible] patients or entity who is

resembling [unintelligible] mitigates the immediate threats.

The New York Association urges an amendment to the SAFE Act to conform to HIPAA standards; that is, disclosure only when there is a significant and immediate threat to the health and safety, which is the threshold in existing Mental-Health Hygiene Law;

And, also, disclosure [unintelligible] reasonably effort to prevent or lessen the threat, including the target of the threat, such as the enforcement agency;

Secondly, mandating all mental-health nurses is not consistent with our scope of practice.

Currently, the submission of serious and imminent danger in New York State Mental Hygiene Law that allow for disclosure of confidential clinical records, are made by treating providers who has the authority to [unintelligible] prescribed.

I'm a nurse. I'm a registered nurse. All I do: I assess the patient, get all the necessary data, and I will give it over to a provider, which is a psychiatrist, or, nurse practitioners, be they are an advanced -- have advanced training. They are the other people that will diagnose, they're prescribed.

So to put that burden on a registered nurse, I don't think is fair on them, and it exposes them to litigation.

And, what are their protection?

And another thing, is that, it's not within their scope.

We know, when you put us outside their scope, you're exposing us to a litigation.

And the first of most, when you go to the Department of Education, when you sit before the board, you have your scope, which a code to work within this scope.

Again, outside your scope, it's not acceptable. It's unprofessional.

Why is the State putting these -- the nurses in danger of losing their license, and all their livelihoods?

And also endangering the patient, because you are not -- you're treating what they're not supposed to do;

And, thirdly, linking gun control with mental illness will increase the stigma on the patient.

The New York Association has serious concern that mental-health-profession reporting requirement will further stigmatize mental health, and may

function as a barrier to treatment for those who need it.

Mental health and gun control are a separate concern, and to promote the criminalization of people with mental health would -- with this broad reporting requirement is an injustice.

I sit with my patient every day. And when you do an assessment, most of the mental patients are they had -- they're delusional.

And when you sit with them, and start to get information, the first thing they ask you: This information, where are you talking it to?

Is it going to be beyond this place?

Is it going to go to [unintelligible] way before this [unintelligible]?

And most of the time that means, how much information are they going to give you?

If they realize that this information, most of them have criminal records.

You know, I mean, the kind of patient I see, [unintelligible], the area [unintelligible] criminal records.

Their criminal record is not that violent. Maybe shoplifting.

With this, this law, they would not give you

much information about them. They will lie.

And when they lie, we're going to be treating something that they are not there for.

How does that help them?

It does not help them.

And it does not help the society to reduce the gun violence.

Most of the gun violence are merely from smugglers.

Few people that have the gun that are registered, there are always a background check that out that are done.

And most of all of the killing from illegal guns smuggled in, and are people buying gun from -- maybe from other people.

How is this going to help?

How is it going to help the nurses?

And how is it going to help the mental-health patients?

It's not going help them.

They will not give you more information.

Most of them would bar themself from coming to get treatments.

So in conclusion, the New York Nurses Association urges the Legislature to work with us to

modify this provision in the SAFE Act, to protect the public well-being, [unintelligible] as a mental illness, and creating barriers to necessary treatments.

In conclusion, also, I thank you for the opportunity you have given to me to represent my association, New York State Nurses Association, to bring our concern up to you.

And we urge you to consider this amendment, and others, to protect, not only the professionals who are dedicated to providing -- the professionals who are dedicated to providing care for those with mental illness, but also to protect the patient and public as well.

Thank you.

Do you have any questions?

SENATOR CARLUCCI: Thank you, Ari. We really appreciate your testimony.

SENATOR VALESKY: I was just going to mention, obviously, we have heard a great deal about the HIPAA concerns, and the stigma, but, I wasn't as aware with your scope of practice concerns, and the potential for liability.

So, I appreciate your specifically bringing that to our attention.

ARI MOMA, R.N.: Thank you.

SENATOR CARLUCCI: Next we'll hear from Beth Haroules, who is the senior staff attorney for the New York Civil Liberties Union.

BETH HAROULES: Hi, good afternoon.

My name is Beth Haroules. I'm a senior staff attorney at the New York Civil Liberties Union.

We are the New York State affiliate of the American Civil Liberties Union.

We have 7 chapters, or regional offices, and, nearly 50,000 members across New York State, and the forefront of our efforts have been our defense of the rights of individuals with disabilities under both the federal Constitution and the New York State Constitution.

I would like to thank the Committee for inviting NYCLU here to provide testimony relating to the implementation impact of the mental-health requirements contained in the SAFE Act.

I'm one of plaintiffs' lead counsel in the Willowbrook case, as well as lead counsel in the **Hirschfeld versus HHC** case.

You may know that the Willowbrook case is a landmark class-action litigation on behalf of people with intellectual developmental disabilities, mental

retardation, or developmental disabilities, initiated in 1972 by my office and others, that was in the vanguard of the civil-rights movement for people with disabilities.

The Hirschfeld case is a pending lawsuit challenging the squalid conditions, substandard mental-health services, and abusive and negligent treatment of adult and child and adolescent patients confined to King County's Hospital psychiatric facilities, a New York City HHC corporation that is operated under the auspices of the New York State Office of Mental Health.

I was also the lead counsel in the Amicus Group that challenged the enactment of Kendra's Law in the case, "K.L.," in 2004.

It's been my experience, as I monitor implementation of two federal consent judgments in the Willowbrook and Hirschfeld matters that the stigma that attaches to people with disabilities, whether it be developmental disability or mental illness, including Alzheimer's and other mental illnesses that affect the elderly, is pervasive throughout society, and persists unbated, notwithstanding continuing efforts to combat the stigma.

The stigma visited on individuals who are, for the most part, poor and marginalized, with no voice in the political system, is particularly severe.

The New York SAFE Act of 2013 is 39 pages long, and it includes wide-ranging changes to New York State laws, from mental health and family courts, to criminal procedure and business laws.

At bottom, the mental-health provisions of the New York SAFE Act rests on fundamental misapprehensions about the highly complex links between violence, mental illness, and gun control.

You've heard it before, and I'll say it again:

People with mental illness are no more violent than the general population, and are, in fact, actually 12 time more likely to be victims of violent crime, as opposed to perpetrators.

Dr. Richard Friedman warned in a "New York Times" article published one month prior to the enactment of the SAFE Act:

That all the focus on the small people of people -- small number of people with mental illness who are violent serves to make us feel safer by displacing and limiting the threat of violence to a

small, well-defined group. But the sad and frightening truth, is that the vast majority of homicides are carried out by outwardly normal people in the grip of all too ordinary human aggression to whom we provide nearly unfettered access to deadly force.

We have three main concerns with the New York SAFE Act:

New York's SAFE Act mandates the creation of an enormous database with no privacy protections, administered by New York State's Division of Criminal Justice Services.

They call it the "Disqualifying-Data Database."

The database contains the names and addresses of all New Yorkers who live under a guardianship order.

This is your grandmother with Alzheimer's that you have pursued guardianship, so that you can manage her funds to keep her at home for as long as possible.

It includes people with a developmental disability. Your son or daughter with Down Syndrome.

And it includes people with a mental illness.

Your son with ADD.

The database is supposed to be used merely to check to ensure there's no licensed firearm, but, there are no privacy protections built into it.

The law does not exempt the Disqualifying-Data Database from FOIL.

The lack of protection afforded the people who are going to be in this Disqualifying-Data Database stands in stark contrast to the new New York State Police-controlled statewide license and record database of the licensed gun owners in New York.

The gun-owners database specifically exempts the records assembled or collected for purposes of inclusion in such database from disclosure pursuant to FOIL.

This is an equal-protection violation.

State and local law enforcement should not have carte blanche access to the names and identifying information contained in this extensive database about people under guardianship, people with developmental disabilities, or people with mental illness, or, people reported under 946.

Law-enforcement personnel routinely perceive New Yorkers living with these disabilities through

the pejorative lens of emotionally disturbed persons, or, "EDP," and New Yorkers are all too well aware that law-enforcement encounters with EDPs generally do not end well.

Research suggests that persons with DD or mental-health issues are 7 times more likely to come into contact with law enforcement than others.

There is extensive public memory of high-profile interactions between law enforcement and individuals with psychiatric disabilities that have resulted in the death of numerous New Yorkers over the years.

This is Eleanor Bumpurs;

This is Giton Bush [ph.];

Kevin Cerbelli;

Recently, Mohamed Bah;

Darius Kennedy.

In addition to these well-publicized incidents, many individuals with DD or mental illness, and their families, have had strained interactions of their own with members of law enforcement.

The public and private experiences create a perception that encounters with law enforcement can have unintended results; injury, or even death.

In New York State, my experience has been, that few, if any, disabled individuals possess, or want to possess, firearms; yet New York SAFE Act calls for criminal investigations of those persons mandated into the Disqualifying-Data Database, and ensures that there will be numerous and potentially adverse contacts initiated between New Yorkers with disabilities and law enforcement personnel who are untrained in mental-health and disability issues.

There's already been a report suggesting additional misconduct by the New York State Police in carrying out their investigations.

There was a suggestion in a permit-revocation situation in Erie County that DCJS and/or the State Police may have had access to the New York State Prescription-Drug Database, resulting in confidential medical information being harvested in order to pull weapons from a person who did not meet the new 946 reporting standards.

The circumstances of that case are murky, but we urge the Committee to conduct oversight over this incident.

You have heard a lot about the 946 mandate.

I won't go into much detail here, other than to note that, again, the reporting mandate

represents a major change in the presumption of confidentiality that has been inherent in mental-health treatment and recognized in New York State, for years, decades.

This privilege is codified in the CPLR.

The reporting requirements you've heard have had -- could have the undesired consequence of deterring people from seeking or fully disclosing during treatment.

I have to tell you, we have consulted as well, as Ms. Anderson noted, with law-enforcement professionals, police, corrections officers, who may be deterred from seeking treatment for fear they lose their firearms, and then their jobs.

We're also very much concerned that there will be the potential for racial bias injected into the 946 reporting regimen.

As you've heard, there is no age threshold with respect to patients who must be reported to DCJS.

And as we also heard, OMH is directing that all children, ages 11 and up, be reported into the database.

We know that many public-school students, most often, young men of color, are inappropriately

transferred from school to psychiatric emergency rooms for psychological evaluation following minor classroom disturbances and disciplinary infractions.

And we've heard today that they're going into the DCJS database, at a point in time where they don't even have a mental illness, much less qualify for 946 reports.

The concern about overreporting is not hypothetical. You heard the numbers today.

It was reported that, in Westchester, they're getting in reports at a hundred a clip, and it's coming out of the hospital emergency rooms' mental-health clinics.

An area that has not been touched on today, except tangentially, is modification to Kendra's Law, that have been affected by New York's SAFE Act.

We -- I -- my testimony deals with three areas.

There's so much more that could be talked about today.

The duration of the initial assisted outpatient treatment order has been extended to one year, from the current six months.

When we litigated "K.L." before the court of

appeals, the court was very assured by the fact that the duration of the initial order was a six-month period, and did not think that there needed to be modification to the due-process provisions set forth Kendra's Law.

By extending that initial order term to a period of 12 months, we think that there is some serious issues with respect to the due-process provisions contained in the statute.

The other provision, which relates to the treatment order, quote, following the person from one county to another when the person moves, it appears to conflict with the mandates of Kendra's Law that requires governmental units, as part of its local or unified services plan, to plan for the provision of services to individuals who may be included in an AOT program administered, supervised, or operated by the locality.

Each local governmental unit is required to plan for the provision of mental-health services to, quote, "high-need patients," as that term has been defined by the Commissioner of Mental Health to include Kendra's recipients.

The treatment order following the plan, the person has the potential to wreak havoc on county

community mental-health planning budgets.

If the county wishes to make the treatment services mandated, under a new residence, Kendra's order are available to that person.

But while the Kendra's order imposes ongoing mandated treatment and compliance obligations on the recipient of the order, the modifications do nothing to mandate the new county of residence to modify its local or unified services plan to plan for the provision of the services mandated to the newly arrived Kendra's-order recipient.

When a Kendra's-order recipient is not compliant with their treatment modality, whether it's because they choose not to comply, or because the services are unavailable, they can be, and are, picked up and transported to a psychiatric facility.

To the extent that this provision [unintelligible] Kendra's-order recipient from relocating within New York State to a different county of residence, we believe that this provision of Kendra's Law [unintelligible] a violation of New York citizens' constitutional right to intrastate travel.

Kendra's law was set to sunset in 2015, and would have been subjected to a fair amount of

scrutiny, as the Legislature has done in each of the past five-year incremental extensions of time.

There is major evidence of racial bias as these Kendra orders are entered.

There is major evidence of geographic uncertainty.

If you're in an urban area downstate, Long Island, or up in the Erie County, you tend to be ordered more frequently than in other of the counties.

The Legislature has very carefully moved forward in assessing the efficacy of the Kendra's regime, and, bumping it out another two years, really, doesn't add anything to the process, and really seems to be gratuitous.

I do want to make a final note on the legislative process before I close here, and, you know, at the Civil Liberties Union, we're particularly concerned about this:

Like many significant areas of recent legislation in New York State over the past few years, the SAFE Act was crafted behind closed doors by the Governor's Office, and pushed rapidly through the Legislature, and immediately signed into law by Governor Cuomo.

There was a message of necessity passed.

20 hours barely elapsed between the introduction of the bill and signature by the Governor.

The Senate approved the measure on its first day in session after the New Year's holiday, at 11:30 at night, and the Assembly on the 2nd.

Few lawmakers, and no one in the public, had time to read, digest, or debate the details, and, no individuals with disabilities or their advocates or mental-health professionals were consulted in connection with the mental-health ramifications of the legislation.

This legislative process makes a mockery of the core democratic principles of transparency, accountability, and public participation in government.

The basic requirements of open government in the legislative process, including public-comment period and robust legislative debate, were completely jettisoned in the enactment of this piece of legislation.

I think most of us who advocate on behalf of New Yorkers with developmental disabilities and mental-health disabilities, the elderly, the young

alike, agree with [unintelligible] reflection that last December's tragic Newtown School shooting has offered all of us a kind of opportunity that only comes once every generation or two: to rethink the entire mental-health system with a focus on re-envisioning community mental-health care, taking steps to ensure more vigilance for problems in young people, and ultimately reducing stigma.

I hope this Committee hearing is the beginning of just such a process.

Thank you for the opportunity to testify today.

SENATOR CARLUCCI: We really appreciate your testimony, and all the work that you've done over the years, with the extensive resume.

So, thank you for your service.

One question that I wanted to ask:

I know you touched upon the Freedom of Information law.

Are there other recommendations from the Civil Liberties Union that would protect people's privacy?

BETH HAROULES: I think you really have to go back.

There were modifications made to the

Mental Hygiene Law Privacy Protections, 3313, that have been reconfigured in a way that, effectively, strips everyone of their privacy rights.

These are putting all of this information that, in the past, for example, there are certain standards for including people with mental-health and developmental disabilities interactions with OMH and OPW into the federal mixed database.

You know, I think you need to go back to where that process is, what those privacy protections are, and, abandon the concept that DCJS has the right to have access to confidential mental-health, developmental disability, elder information. There's no need for them to have a database of all of these people.

It should not be administered by a criminal-justice entity.

I mean, these are not people who need to be tarred with a brush of criminal-justice oversight.

These are people with disabilities.

And, so, you know, our basic recommendation is, it needs to be jettisoned, and you really have to come to the table with all of the people, you know, including many of the suggestions that were made today, to look at exactly what it is that is

trying to be accomplished here.

You know, as I said, most people with disabilities don't want weapons.

You know, the grandmother with Alzheimer's, you know, it may be her family's guns, you know, but, presumably, the family is already looking at that.

DCJS is not going to send the State Police in to batter down a grandmother's door, you would think, but they have the right to do that.

And, there is no clarity, there are no guidelines.

And I think what we've heard is: Everybody into the bin, because nobody wants to be the person that the "New York Post" reports on, for having failed to exercise appropriate judgment; for the State Police having to fail, you know, to go to their door, because they were in the database.

You really need to start at square one with this.

And there's a lot of us who are willing, and available, to assist in the process.

SENATOR CARLUCCI: Great, thank you.

SENATOR VALESKY: One more question?

SENATOR CARLUCCI: Yeah, please.

SENATOR VALESKY: Has the Civil Liberties Union looked at the Pretlow bill that's been referred to by a few previous speakers?

BETH HAROULES: No, actually, and I would be interested in seeing what that does.

You know, I think there are a lot of -- you know, obviously, there are concerns when you have bills that are introduced on behalf of providers, versus, the actual advocates and the constituents who are the people that are going to be impacted.

I did, actually, on the California law that was alluded to, California is the state that has the Tarasoff case in place.

It's a case, I believe from the '80s, where reporting obligations imposed on treating mental-health providers sort of came to first light.

And the California statute, as I understand it, tracks very much what the requirements that were imposed on treating mental-health professionals are under the California Supreme Court case out there.

So, it's a little bit of a different reporting regime.

I know clinicians are trained on that.

The New York, sort of, approach has mirrored that, but there's never been a Tarasoff reporting

requirement in New York State. And I think you need to look at what Tarasoff was, who it applies to.

In my submission, I also pointed out the irony of the fact that, for all of the mandated groups of individuals under 946, State workers are exempt.

So, there doesn't seem to be really -- you know, if you're looking at who the appropriate reporters are, to exempt out a lot of people who are working off licensing out of New York State Education simply because they're employed by a state developmental disability setting or an Office of Mental Health facility, it -- really, there's no logic there.

SENATOR CARLUCCI: Great. Thank you.

SENATOR VALESKY: Thank you very much.

SENATOR CARLUCCI: Next we'll hear from Kim Williams, who's the director of the Center for Policy, Advocacy, and Education for the Mental Health Association of New York City.

KIM WILLIAMS: Hi.

So, good afternoon.

SENATOR VALESKY: Hello.

KIM WILLIAMS: Senator Carlucci, Senator Valesky, thank you for the opportunity to

testify this afternoon on the provisions of the New York State SAFE Act relating to mental-health services and mental-health-professional reporting requirements.

My name is Kimberly Williams. I'm the director of the Center for Policy, Advocacy, and Education at the Mental Health Association of New York City (MHANYC).

MHA is a not-for-profit organization that has a three-part mission of direct service, advocacy, and education, and, is a national leader in ensuring that people in emotional distress get the help they need.

And, our policy center promotes the development of an advocacy for mental-health policies and services that support high-quality practices designed to meet the mental-health needs of the diverse population in New York, as well as across the United States, and to provide training, technical assistance, and public education.

MHA of New York City is deeply concerned about the impact that the New York State SAFE Act will have on the rights of, and access to care for, people with mental illness.

This law erroneously associates mental

illness with violence and dangerous criminal behavior, further stigmatizing people with mental illness, and which may, in fact, prevent people from seeking the care that they need.

As has been stated, murders and overall violence are extremely rare by people with mental illness.

And, in fact, only about 4 percent of violence in the United States can be attributed to people with mental illness, and most of these violence -- violent acts do not involve guns.

In fact, firearms result in nearly twice as many suicides than homicides in this country every year.

And while the mental-health components of this law are intended to protect individuals who may be of harm to themselves, it may actually deter people from seeking treatment, or fully disclosing to their therapist or doctor their suicidal ideation, for fear of losing the right to possess firearms, and, fear around privacy issues.

Additionally, longstanding laws, as have been noted, already encourage mental-health professionals to warn the appropriate parties if they believe clients are in danger of harming themselves or

others.

Therefore, the SAFE Act is unlikely to identify dangerous people who would not otherwise be reported; but, rather, instead, discourage people from seeking help in the first place.

The real mental-health issue in gun violence is suicide, which we need to be confronting in a non-stigmatizing manner that encourages people to get help.

Firearms are the most common and most lethal method of suicide.

And as I already stated, they result in more suicides than homicides each year.

Access to firearms dramatically increases the risk for completing suicide due to the lethality of gunshot wounds, which occurs so quickly, and with such force, that suicide attempts using firearms leave people with little opportunity to survive a suicide attempt.

While over 90 percent of people who survive a suicide attempt will not go on later to complete suicide, people generally do not survive self-inflicted gunshot blasts.

If we want to reduce gun violence in the state of New York, we need to focus on effective

means for suicide prevention that do not infringe on an individual's right to privacy, but that do reduce a suicidal person's access to highly lethal means, and foster, not discourage, getting help.

Limiting access to guns during periods of vulnerability is critical to saving lives.

Limiting access is not about gun control or about permanently removing firearms, but about safe dispensation, use, and storage of legal firearms.

Limiting access to lethal means is also about ensuring that health and mental-health professionals are trained to assess for risk of suicide, and on how to counsel individuals at risk about limiting his or her access to lethal means until they are no longer in crisis.

This is known as "lethal-means counseling," and it involves acquiring of the individual, and with permission from his or her family members, about whether there are firearms or other lethal means in the home, and working with them to temporarily, rather than permanently, limit access until the crisis is averted.

Local law enforcement or a family member or a friend may be able to temporarily store the firearm until the circumstances improve.

Suicidal crises do not last. Many have an impulsive component and occur during a short-time crisis.

To implement the suicide-prevention approach on a wide scale, professional groups can add lethal-means-counseling protocols to their current suicide-prevention protocols.

Providers can also get trained in firearms-safety-counseling methods, such as the CALM training, which stands for "counseling on access to lethal means."

Another important and innovative way to limit access to lethal means is to partner with the gun-owning community to increase their involvement in promoting suicide prevention.

This promising approach, which is being implemented in other states, includes incorporating suicide-prevention awareness as part of basic firearms-safety training; developing guidelines with gun-store and firing-range owners about how to recognize a customer who is in distress, and avoid selling or renting a firearm to a customer; and encouraging gun-store and fire-range owners to display and distribute suicide-prevention materials.

We are fortunate at the Mental Health

Association to have received a small grant from the New York State Office of Mental Health to pilot such a suicide-prevention initiative.

It's a gunshop project here in the state of New York which we'll be implementing over the next few months, and will be happy to share with you some results of that project.

If we can implement commonsense approaches, these commonsense measures like these, as part of a comprehensive approach to suicide prevention, we can increase the time that passes between impulse and action; and, therefore, increase chances of survivor, all while maintaining an individual's rights, and encouraging help-seeking.

We encourage the New York State Senate to use this opportunity to save lives by doing more about the most common way in which guns cause death: by supporting comprehensive suicide-prevention efforts that incorporate limiting access to lethal means, including firearms.

Thank you for the opportunity to testify.

SENATOR CARLUCCI: Thank you, Ms. Williams.

And we look forward to working with you as the Mental Health Committee, and working on strategies towards effective suicide prevention.

So, some of the items in your testimony are very helpful, and we look forward to hearing more from you in ways that we can work together.

KIM WILLIAMS: I would be happy to share more.

SENATOR VALESKY: Thank you for the work that you're doing right here.

Thanks.

KIM WILLIAMS: Thank you.

SENATOR CARLUCCI: Thank you.

And that completes the list of speakers.

I think we have everyone.

Is there anyone else in attendance that wanted to speak?

Okay.

Well, we appreciate your time, and for being here, and working with us, to make sure that we fight stigma with mental health, and make sure that we do what is intended in this law: to protect people, and to keep people safe in New York State.

With that, I want to thank everyone for attending.

And, this hearing of the Mental Health Committee is adjourned.

Thank you.

(Whereupon, at approximately 3:41 p.m., the public hearing held before the New York State Senate Standing Committee on Mental Health and Developmental Disabilities concluded, and adjourned.)

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Western New York Legislative Forum on
School Safety, Mental Health, and Gun Violence
February 13, 2013

Testimony from the Mental Health Association of Erie County, Inc.

Two months ago, 26 people – including 20 young children – were murdered at Sandy Hook Elementary School in Newtown, Connecticut. We're here today to do everything in our power to make sure that never happens in our community.

All three of the issues being addressed at today's forum – school safety, mental health, and gun violence – are vitally important. Each demands our attention. But we are concerned that when they are lumped together, this discussion often further stigmatizes people with mental illness.

The recently enacted New York State SAFE Act is a case in point. We believe it unfairly singles out people with mental illnesses. Both science and research tell us that these people are 12 times more likely to be victims – not perpetrators – of violent crime. We must stop associating violence with mental illness.

Most violence is not committed by people with a mental illness. That is one of the most insidious stereotypes. The seriously mentally ill, in fact, are involved in only 4% of violent crimes.

We know that one in four Americans deals with a mental illness. They are your neighbors, your co-workers, your friends…maybe even your children or parents. By perpetuating stereotypes and stigma, we inadvertently push people away from the support and services they need to move toward recovery and wellness.

Unwittingly, the SAFE Act may also have the unintended consequence of deterring people from seeking care or fully disclosing their concerns to their therapists or counselors. We reject the criminalization and psychiatric profiling of people with mental illnesses. The use of registry data must not extend – and cannot be shared – beyond gun-related purposes.

Delaying treatment is especially troubling for young people. We know that 75% of all mental illness appears before age 24. And it often takes decades for people to seek help. Tragically, four out of every five young people who struggle with a mental illness never receive treatment.

If we all know that we have a problem, what are the solutions? In our remaining time, we'd like to identify actions we can take as a community to strengthen mental health and wellness. Even though most of us are mentally healthy most of the time, we realize that good health must be nurtured and protected, especially among our most vulnerable, which certainly includes our children.

We'll conclude our remarks with a few suggestions on how we can more effectively respond to our friends, family members, and fellow New Yorkers who struggle with a mental illness.

In New York, more than 300,000 of our young people are living with a *serious mental health condition* that significantly impairs their daily functioning. In Erie County, that's enough children to nearly fill the First Niagara Center to capacity, or approximately 15,000 children. Still our education laws show little, if any, recognition of the need to teach about this critical aspect of health.

More than 50% of students labeled with emotional or behavioral disorders drop out of high school and, of those who do remain in school, only 42% graduate with a high school diploma. Many high school graduates go to war, most who were never taught about Post Traumatic Stress Disorder, or PTSD.

Other young people have parents returning from war, some with serious mental health needs. Many will require treatment. Every day, 22 veterans in the United States kill themselves. That's a tragedy of Sandy Hook proportions every single day. We've asked a lot of our military over the last decade. We owe them – and their children and families – better care than we've given them so far.

A lack of knowledge, coupled with stigma, discourages many people from taking full advantage of today's treatment options in a timely manner. This is both serious and disturbing since untreated mental illness tends to become more severe over time and, in extreme cases, often ends in suicide or self-injury.

Suicide is the third-leading cause of death for young people ages 15-24. More than 90% of young people who die by suicide were suffering from depression or another diagnosable and treatable mental illness at the time of their death. We do young people a disservice by remaining silent about mental health conditions like depression, eating disorders, and PTSD.

Unfortunately, in most New York State classrooms, there is little or no discussion of mental health. Without a clear policy direction and intervention from lawmakers, there is little hope of breaking this silence.

By ensuring that young people are educated about mental health, we improve their ability to recognize signs in themselves and others, including family members, then

get the right help. As we begin to teach the facts about mental health and openly discuss the issues, we also lessen the stigma surrounding mental illness.

Mental health is an essential element of overall health, and should be included as an integral part of health education in schools. Our public education system in New York has long recognized the value of health education. We have updated this statutory imperative to include education in alcohol, drugs, tobacco abuse, and the prevention and detection of certain cancers. The time has come to include mental health education. To that end, we support Assembly Bill 1911.

Our educational focus must shift from just recognizing and treating illnesses to preventing them and promoting better mental health. Just as we incentivize people to develop good physical health habits, so too must we identify, then support good behavioral and emotional health. At the federal level, this is why we support HR 751, the Mental Health in Schools Act.

Any comprehensive approach to mental health education must include screening, which can identify emotional and behavioral issues early, often before they develop into full-blown disorders. Screening increases the likelihood that people in need get help, while minimizing the adverse impact on their life.

In light of the direct and indirect annual costs – estimated at $247 billion – investments in early intervention programs, especially those that better connect health and education systems, should be prioritized.

In addition to making mental health screening and education available to all of our young people, we also need to expand and strengthen the mental health services in our community, which have endured a series of devastating cuts in recent years.

People can and do recover and they do it best when there is strong care coordination, peer services, housing, family involvement, trauma services, suicide prevention, mobile crisis teams, clinical interventions, diversion programs, and other services. We support sweeping Medicaid and mental health reforms that will solidify this wide array of strategies and services.

Finally, we urge New York to require mental health parity across all private insurance plans, Healthy New York, and in the new Health Exchanges. We must do everything in our power to ensure that people diagnosed with these debilitating and sometimes life-threatening disorders will not suffer needless or arbitrary limits on their care.

On behalf of the nearly quarter-million Erie County residents who struggle with mental illness – especially our young people, who represent the future of this community – I thank you for convening today's forum.

Intelligent investments in community mental health services will help keep people, especially young people, out of the criminal justice system, out of hospital emergency rooms, and out of psychiatric units. They will help many people regain their hope, their lives, and their futures. They will save many families from untold heartache and loss. They will also save taxpayer dollars.

I can think of no better way to honor the lives of the 20 children who lost their lives at Sandy Hook. No better way to honor the lives of our own children.

Thank you.

Dr. Peter Faustino

New York State Association of School Psychologists

Good morning.

Assemblywoman Jane Corwin and Assemblymen John Ceretto, Raymond Walter, and David DiPietro, thank you for inviting me to speak on behalf of the NY Association of School Psychologists.

My name is Dr. Peter Faustino and I am immediate Past President of NYASP. Several colleagues could not be in attendance today as this happens to be the same week as our national convention. President Kelly Caci, Legislative Chair John Kelly, and Board Member Amanda Nickerson, from your very own Alberti Center for the Prevention of Bullying Abuse and School Violence at the University at Buffalo were integral in drafting this testimony and wanted me to express their desire to engage in a future dialogue at your request.

The NY Association of School Psychologists has long been a leader in promoting safe, supportive learning environments; ones that protect both the physical and psychological safety of students and staff. So we applaud this panel on committing to identifying concrete and comprehensive strategies to ensure that we meet our responsibility to every school, every child, every family, and every community in NYS. We strongly posit that any strategies on school safety must include addressing mental health. We believe that effective policies MUST be built upon **known evidence-based strategies** and practices as well as collaborative efforts between schools, families, and communities.

With the Governor's signing of the SAFE act comes the urgency to not allow the light shed on this issue by the tragedy in Newtown, CT to dim without our leaders taking real, meaningful action. In reviewing and reading the different components of the SAFE act, many elements have great promise. While we believe that the events in CT were too important not to expedite action, we greatly appreciate the critical steps and substantive work at hearings like this. NYASP is committed to helping guide policies that lead to increased physical and psychological safety in schools by providing the recommendations outlined below. And endorsing the efforts of other allied organizations and experts, such as the December 2012 Connecticut School Shooting Position Statement released last month by the Interdisciplinary Group on Preventing School and Community Violence.

I would like to acknowledge at the outset that I have chosen to focus on the topics with which NYASP has the most expertise and are closely related to our mission, but we recognize that violence prevention is a multi-layered issue that warrants attention to the availability and misuse of weapons or media influences on youth.

The goal of my remarks today is to highlight common ground and practical strategies, of which there is a great deal among school safety experts. Further, I will strive to ensure that the focus moves beyond the historical practice of primarily increasing school building safety measures

(e.g., metal detectors, armed security guards, surveillance cameras) and instead focus on addressing the continuum of needs and services that lead to improved safety, well-being, and learning for children and youth.

NYASP calls upon all legislators in NYS to follow your lead and amend or enact legislation that addresses the following primary areas for improved policy and practice:

Given that I work in a school, everything gets boiled down to ABC or 123, so I have consolidated our main points into 3 issues.

Issue #1: Increasing access to mental health services and supports in schools.

Good mental health is critical to children's success in school and life. Mental health is not simply the absence of mental illness but also encompasses social, emotional, and behavioral health and the ability to cope with life's challenges. Left unmet, mental health problems are linked to costly negative outcomes such as academic and behavior problems, dropping out, and delinquency. Approximately 1 in 5 adolescents has a diagnosable mental health disorder, making these disorders one of the leading causes of disability among this age group. However, studies have found that most children and adolescents with mental health disorders do not seek out or receive the services that they need. Estimates suggest that between 60 and 90 percent of adolescents with mental health disorders fail to receive treatment. Of the adolescents who do get help, nearly two thirds do so ONLY in school. A recent SAMHSA-funded study revealed that two thirds of school districts reported that the need for mental health services has increased since the previous year, while over one third of these districts also reported a reduction in mental health program funding.

Multiple challenges exist in trying to connect adolescents with mental health disorders to the services and treatments that can help them attain a better quality of life. School leaders who recognize the relationship between student success, good schooling/instruction, and comprehensive school health programs that include attention to students' mental health will more effectively improve student and school outcomes. Additionally, close collaboration between school-employed (e.g., school psychologists and school social workers) and community-employed mental health services providers is critical to meeting the full range of mental health needs.

So what can be done?

NYASP asks that NY Advance legislation which provides for licensure of school psychologists, currently A3570 submitted by Assemblywoman Rosenthal AND the same as S2923 submitted by Senator Flanagan

Publicly funded insurance pays for a large portion of adolescents' mental health care. Coverage for children through Medicaid and SCHIP was expanded recently through a Reauthorization Act in 2009 and The Affordable Care Act of 2010. These efforts will further improve access to behavioral health treatment for children and adolescents in schools. Despite our political viewpoints on this, New York State is limiting their ability to access funds for school-based psychological services. The vast majority of school psychologists in New York are prevented by

their current credential from being considered "Medicaid Qualified Providers." No credential exists for these professionals to obtain this status. Therefore, school districts are unable to claim for psychological services provided to Medicaid eligible students. An analysis of Medicaid reimbursement for school-based psychological services indicated that this represents approximately $100 million in untapped revenues to school districts. The licensure of school psychologists, which would allow for "Medicaid Qualified Provider" status, requires action on the part of the New York State Legislature to restore these funds.

To illustrate this point, The Medicaid numbers for the Buffalo city schools for psychological counseling during the 05-06 year was $1.2 million. For the Rochester City schools it was $1.7 million. Even smaller school districts like Lakawanna City schools or the Kenmore UFSD, for example, Medicaid reimbursement was approximately $100,000. 2005-2006 was the last full year that school psychologists were qualified providers. While school psychological services are one critical aspect to this conversation, it follows an overall trend in loss of Medicaid dollars and is evident by the comparison that in 2004, Buffalo City schools received total Medicaid reimbursement of $23 million. In 2009; it was down to $4.5 million. Rochester's numbers for 2004 were $14.5 million in reimbursement from the federal government...in 2009 just $4.5 million.

Passing the proposed legislation that is currently in both houses would go a long way to bringing necessary funds to the children most in need.

Issue # 2 Improving crisis prevention and preparedness procedures.

Schools must provide the infrastructure to develop and maintain active school safety and crisis teams that focus on efforts year-round to promote a safe, positive school culture while minimizing the impact of school crises when they occur. This entails a multi-tiered approach consistent with other school systems of support—which includes universal screenings and interventions as well as more intensive approaches for students deemed at risk. School mental health professionals (like school psychologists and social workers), in collaboration with families and educators, remain our greatest resources to helping identify students at risk for violence to themselves or others, and identifying interventions and supports to help minimize those risks.

We know from the U.S. Secret Service study on school shootings that there is no "profile" for a school shooter. Therefore, it is ill advised to try to pinpoint characteristics that might suggest that a student will be the next shooter. However, the U.S. Secret Service report did find that the shootings were planned carefully, and that other people often were aware of the plan. Educating the school community and larger public about how to report threats and having threat assessment procedures in place to identify the extent to which a threat is substantiated or unsubstantiated is a practical and important step. Effective screening and assessment also requires interagency collaboration and communication across education, health, mental health, and law enforcement.

So what can be done?

NYASP suggests conducting a state-wide campaign to reduce stigma around mental illness and to promote access to mental health services.

Among the general public, there is fear and stigma of people with mental illness when, in fact, people with mental illness are far more likely to be the victims than perpetrators of violent crime.

*recently I was speaking to the father of boy with mental illness, who thanked me for helping find appropriate educational services for his son but asked what I could do to help educate the community about what the family was struggling with. He shared the rejection they experience in their neighborhood or at the ball field.

This stigma reduces the likelihood that families and students will seek out and receive the mental health supports and services needed to learn and thrive in school and throughout life. Given the natural interaction between physical and mental health, the importance of caring for an individual's mental health needs must be on par with the importance of physical health.

These efforts should promote **wellness** as well as address mental health needs of all community members while simultaneously responding to potential threats to community safety. This initiative should include a large scale public education and awareness campaign, along with newly created channels of communication to help get services to those in need.

More public information (such as these proceedings) can de-stigmatize mental illness and are a wonderful starting point for discussions on ways to promote mental health. These conversations have begun at the national level and NYS (if interested in leading the way towards safety and security) must recognize that legislation like the SAFE act is only one small step toward increasing safety. The next step is collaborating and partnering with the representative groups here today. There exists a wealth of resources in NYS and we welcome being at the table.

Issue # 3 Maintaining safe and supportive schools.

Despite the horror that we all feel after the shooting in Newtown, CT, schools remain one of the safest places for children in the United States. We need to continue to focus on how we build and maintain safe school environments that promote learning, psychological health, and student success. We need to ensure that adequate learning supports and policies are present to provide a continuum of services that respond to the needs of all students. Critical to this is enhancing school connectedness and trust between students and adults as well as reinforcing open communication and the importance of reporting concerns about someone hurting themselves or others.

Indeed, the primary focus of school-based mental health services is to provide students with the necessary supports to thrive in school and throughout life. Providing ongoing access to these services promotes school safety by helping students feel connected and supported and by helping to identify students who may need more intensive services.

So what can be done?

NYASP recommends that NYS legislators take a careful look at unfunded mandates that may be able to provide financial relief to schools so they can maintain safe school environments.

NYS needs to examine unfunded mandates. There are several unfunded mandates that do NOT impact children's programs. As an example, we are calling for Wicks Law to be repealed as it is not cost efficient and does not directly impact children and families.

Another is streamlining paperwork and reporting procedures. SED has repeatedly advanced a bill that would reduce the number of individual reports required by the state. Any effort that would reduce or eliminate the excessive and often duplicative reporting requirements imposed on school districts would be extremely helpful. Many of the current requirements divert staff time and resources from districts' primary objective of educating students. Given tight fiscal constraints, school districts must be freed from administrative restrictions and mandates that hamper their ability to devote every education dollar to the pursuit of educating every child.

But in an effort to provide relief we must ensure that other mandates which represent good educational practices as well as built in rights for children and families, are not altered. Some may say that ALL mandates are ill-conceived but they are NOT created equal. Currently, school districts have flexibility with many of the special education mandates in our current educational law. For example, regarding the Committee on Special Education composition, any committee member may be excused with permission of the parent. In addition, committee members can serve multiple roles during those meetings further streamlining the cost efficiency.

Restraint must be employed in making over-inclusive demands for "mandate relief" to ensure that New York State does not jeopardize the educational advancements of our students. At the same time, we call for a consideration of the mandates that do not directly impact our students and instead contribute to increased time and costs that take away from schools' primary goal.

In Conclusion:

Effective school safety is a day-in, day-out commitment that infuses every aspect of school life. Our challenge is to not let increased anxiety over this horrible tragedy obscure the proven fundamentals of violence prevention. Instead we must become more unified, vocal advocates for policies that support what schools are doing and CAN do effectively, which in turn supports the primary mission of learning. We must create and pass legislation to reduce and prevent violence in order to promote the well-being our children and youth. An investment in school mental health services is an investment in that prevention.

Thank you!

For more information, visit www.nyasp.org or contact NYASP Legislative Chair Dr. John Kelly at legislative@nyasp.org